Project WELCOME

Working Efficiently with Local Staff and Customers on Medicaid Eligibility

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Problem Statement:

The South Carolina Department of Health and Human Services (SC DHHS) is responsible for administering and managing the state of South Carolina's Medicaid program. The SC Medicaid program provides health coverage and health related services to South Carolina's need based population. This population includes low income, disabled, elderly, among others. The Medicaid program has developed a stigma and stereotype of being the "poor people's" health insurance program with which many folks do not want to interact. However the agency's mission is to provide the best healthcare value for South Carolinians. Notice that this mission does not categorize South Carolinians by income, disability or any other category; the agency is here to provide the best health care value for all citizens. Although much focus is placed on the types of healthcare services that are covered and the levels of healthcare that are available, the attention to customer service for our beneficiaries and workforce has great room for improvement. Customers for this project will encompass both beneficiaries and SC DHHS employees.

The eligibility determination branch of the agency is the face of our agency with the public. This area is responsible for the intake of applications, re-determining of eligibility and ongoing maintenance of Medicaid determinations. Currently there is a local eligibility office in every county with several counties having multiple eligibility offices. The agency's State Office located in Columbia, S.C. is responsible for oversight of the Medicaid program and setting policies for the state to follow. There is a perception with local eligibility staff that State Office staff is not concerned with local eligibility

issues since State Office staff does not have to deal with the public on a daily basis. However our agency has defined the following goals:

- To provide a credible and continually improving eligibility process that is accurate and efficient,
- To provide administrative support at the best possible value to ensure programs operate effectively.

These goals can only be obtained by State Office and local eligibility staff working together. This project is focused on improving the eligibility process and making sure the administrative support is in place to help our agency achieve these goals.

Our agency has also published the following characteristics by which we will do our jobs:

Service:	we are dedicated to service; we will place others first.
Excellence:	we are committed to constant improvement and will persevere in achieving quality with efficiency.
Responsive:	we will be alert and react quickly to the needs of those we serve; we embrace opportunities to improve our processes.
Value:	we will ensure that all of our decisions and actions will be measured by the value they return; we guarantee honest and open measurement of outcomes.
Everyone:	we are a team; every employee is involved in our success; we believe in servant leadership and empowering employees to solve customer problems; as a team we will encourage and hold each other accountable.

Based on the feedback from DHHS staff alone, it is apparent that our agency has room for improvement to satisfy each of these characteristics. This project will try to provide a roadmap to options that will encourage these characteristics throughout the agency.

The agency's area for constituent services, call center, executive staff and many other areas receive complaints from the public regarding case workers, local eligibility offices, errors in processing, and other issues. Our agency also receives complaints from caseworkers regarding the public, office locations, mandated procedures, computer systems, among other topics. This project will focus on identifying the most visible

common issues that both parties are facing and try to provide options to help solve these issues.

Based on data collected for this project and ongoing perceptions, there are four areas that will be reviewed and steps outlined to improve issues with each area. First, SC DHHS provides outgoing correspondence to beneficiaries through mailings. This includes initial approval letters, denial letters, closure letters, informational notifications, and cards. The agency has experienced frequent issues with returned mailings for bad addresses. Beneficiaries also frequently complain that the agency mailings never are delivered to them. Next, beneficiaries often state they cannot reach their worker, either by phone or in person. Since eligibility workers are the current intermediary for the public and their eligibility status, this is a key area that needs to be addressed. Third, one of the goals outlined earlier is "to provide administrative support at the best possible value to ensure programs operate effectively," this can be done with humans and technology. One of the essential parts of the eligibility process is documentation of the interactions with the beneficiaries during the Medicaid workflow. Currently there is no consistent way to view the state of an application or the beneficiary's interactions in the Medicaid eligibility process. Last, the agency has county offices in every county that are grouped in eight regions throughout the state. Currently each region, and even at the county level, the eligibility offices are located and operate in inconsistent formats. This project will concentrate on finding a more consistent and effective model for operating the local eligibility offices with the goal of providing a more accurate and efficient experience for the Medicaid beneficiary.

Data Collection:

For this project, surveys were the first choice for collecting the needed information to identify the issues in the eligibility process. The first survey in Figure 16 was sent to pre-selected SC DHHS employees that were identified by local managers as the individuals who interact with beneficiaries the most. There were 34 employees identified and 28 responded to this survey (82.4% completion rate). The second survey in Figure 17 was sent to our approximately 530 SC DHHS eligibility workers. Of these, 452 employees started a survey and 423 workers completed the survey. This data identified the areas of concerns that guided the focus of this project. Figure 1 identifies the top complaints by beneficiaries that the first group of 28 surveyed employees identified that have been disclosed to them when interacting with the beneficiaries. Policy was identified as the biggest complaint, however since most policy is defined by federal regulations, this issue was out of scope of this project and the detailed responses were given to the area responsible for policy and oversight. The next three biggest complaints were "can't reach worker", "notifications" and "timeliness". These three can be addressed through this project and will be the nucleus of the focus for the processes to be improved. As Flanigan and Scott recommend, "Allow your customers to define the target"[1], this is crucial in our eligibility area since the customers are the targets of our improvement efforts.

Figure 2 further illustrates the concern to allow customers to define what needs to be improved by showing what the front line eligibility workers see as the biggest barrier compared to management's perceptions. The normal response from management concerning what is the biggest barrier for case workers is that they receive too many phone calls, have too many face to face interactions with clients or their caseloads are too

[1] Flanagan, Eileen M. and Scott, Jon. Process Improvement, p. 17

large. However you will notice that only 14% stated that beneficiary interactions were their biggest barrier. Required documentation was voted the biggest barrier and although most documentation is required by law, this project will address the documentation that is in scope for this project. The importance of capturing the whole picture of what the eligibility workers are facing is illustrated in Figure 3. Although required documentation was voted as the biggest barrier, notice that the workers do not spend a lot of time on gathering this documentation. It is important to differentiate between the barriers and what consumes the most time.

In the next illustration, Figure 4 shows that over 93% of responders stated they have a tracking system. A tracking system is defined as a system for documenting each step of the eligibility process for a beneficiary, for example notations are made when an application is received, when a client calls, and when the case is approved. At first glance you would think that the agency has satisfied its need for being able to track the work that a caseworker has performed on a case. However, if you look at Figure 5 you can see workers use Microsoft Excel, manual paper process, MEDS notes and other similar programs to track work. There is no consistent format for tracking, so you would have to contact a worker individually to interpret their notes, or find their Excel spreadsheet. This need for a universal tracking system is critical in the eligibility process and would provide benefits for every level of staff at the agency.

Another area that was a concern before these surveys was the issue of old addresses in our system, this issue was confirmed after reviewing the surveys. In Figure 6, you will notice that staff is predominately gathering new addresses about once a year at time of new application or review. The Medicaid population has always been a transient

population. In some cases, new applications or reviews are years apart so addresses are not updated over longer periods of time. Gathering and updating beneficiary addresses is important in reducing returned mail and additional steps to be completed by eligibility workers after cases are closed because of returned mail. Figure 7 represents the amount of returned mail and illustrates the need to provide options to help reduce these numbers. Since 2002, when the updated Medicaid eligibility determination system (MEDS) was implemented, the annual reviews were moved from a manual process to an automated process. MEDS sends out the review forms and if they are not returned the cases are automatically closed. Therefore, the importance of the beneficiary receiving the review notice and completing it is more crucial than before. In Figure 8, you will notice the amount of cases closed for failing to return review forms for the given four month time period in 2008. This is important for beneficiaries and caseworkers because when the case is closed the beneficiary usually comes back into the office to get the case reopened. As a result, the workers have to process the case anyway and the beneficiary is inconvenienced since they have to come in and reapply instead of completing the mailed in review form and the beneficiary may not have been able to receive services while the case was closed. The question of why the beneficiaries are not completing the review forms is a major concern and will be addressed in this project.

The overall importance of this project was validated by eligibility staff in Figure 9. You can see that 92% of the responders believe the eligibility process needs improvement. Interestingly, one consistent theory over recent years of the area that needs to be improved for eligibility staff is debunked in Figure 10. Most believe that caseworkers are all over burdened and production has suffered because caseload sizes are

too large. Almost 60% of staff believe their caseloads' size are manageable. Even though caseload size may be an issue, the eligibility staff's response will be the guide on which areas to address.

We conducted a phone interview with the state of Idaho to gather their input on their recent success in implementing a regionalized Medicaid processing unit. Although their Medicaid business is different than South Carolina, they did reiterate that separating the intake and processing/maintenance units was essential to their success.

Data Analysis:

After reviewing the results of the surveys and analyzing the caseworker reports it is apparent there is a need to make appropriate changes for both the beneficiaries and the eligibility workers. The results also point out that some existing perceptions were somewhat confirmed and others debunked.

The majority of caseworkers felt their caseload sizes were manageable, a conflict of an existing perception at the agency. The caseworkers revealed that documentation was the biggest barrier but not the most time consuming. This is interpreted as documentation is too difficult to complete in the current format. Therefore a recommendation of creating a universal tracking system for documenting case work will be addressed in the implementation plan below which will consist of consistent training and policies for the entire state. Staff needs to understand the benefits to them to truly buy-in to this additional step. As Flanigan and Scott state "the entire idea behind having a process is that the process creates an output that the customer values"[2]. In this scenario

[2] Flanigan, Eileen M. and Scott, Jon. Process Improvement, p. 53

the customer is the worker and they must see value in documenting their work for this to be beneficial.

Since the survey results reported that beneficiaries do not feel they can reach their worker and cases are not processed timely we must take a look at how work in the local offices is completed. Our agency has been in discussion of organizing our eligibility offices into intake and processing/maintenance units for several years. However no consistent and universal decision has ever been made. The state's largest region, Charleston, has started and implemented a model of separating the units into intake and processing/maintenance. After visiting the Charleston area to review their model, there were both positive and negatives found. The intake unit was able to handle a vast number of beneficiaries in a given day and the processing/maintenance unit was able to process large numbers of cases without any public interruptions. However, the intake unit was grossly unorganized and the office was located predominately in a hall of a dental clinic in a hospital. This issue will be furthered discussed in the implementation section below. This model was successful in creating an environment that allowed beneficiaries to reach their workers and allowed workers to focus to be able to process cases more accurately and efficiently.

After reviewing the survey results and reviewing the Charleston area, we will focus on improving the notification process, improving ways for beneficiaries to reach their caseworker and improving efficiency in timeliness.

Implementation Plan:

Based on the above analysis, the first area to be examined is the notification process for Medicaid eligibility. The predominant complaint from beneficiaries

concerning the eligibility notification process is that they do not receive their annual review forms. However the process for creating notifications (notices) is the same for approval letters, denials, closures, and reviews. Since MEDS was implemented and cases are now closed because of not returning the review form, the issue of beneficiaries not receiving these is elevated. Actual delivery of the notices is assumed since all notices follow the same method of creation and delivery. Currently companies are bombarding mailboxes with junk mail, and advertisements. Therefore it's very important that the agency concentrates on creating notifications that uniquely identify themselves versus all of the other correspondence that is filling the beneficiaries' mailboxes. The agency has to focus on branding their image on these notifications. Since this issue is of high importance it was my recommendation to initiate these changes immediately. The agency has decided to use our Healthy Connections logo, which was created several years ago to brand our Medicaid program. HIPAA regulations prevent placing the word Medicaid or any other Medicaid related verbiage on outgoing correspondence, therefore we will use our Healthy Connections title and logo on all envelopes that are sent from the agency. We are implementing a policy in our procurement area to always include the title and logo onto any envelopes that are ordered. We are also coordinating with vendors that produce notifications to our beneficiaries that are from our agency to also use the same colors, logos and titles as well. In Figure 11 you will see the previous and new version of the review envelopes and in Figure 12 you will see the previous and new version of the other MEDS generated notices. The goal is that the use of a consistent branded image throughout the public will help identify the documentation from the Medicaid program so

that the public will open this information instead of discarding. This process was started about 2 months ago and should be completed by mid-2009.

Next the issue of having accurate addresses for our clients will be handled in two ways. First, the agency will need to develop a consistent script for all workers to use when talking with beneficiaries. This script will query the beneficiaries for their up to date address. The agency will need to implement this script across all personnel that interact with beneficiaries regarding eligibility and require this script to be completed every time they communicate with a beneficiary. A quick example of a draft script would be, "Thank you for calling, please take a second to confirm the address we have on file. Can you tell me your current mailing address? Thank you". We will set a goal of having this new procedure in place by July 2009. Next, the agency uses the Division of State IT for creating and mailing their notifications. State IT is partnering with a vendor to gather up-to-date forwarded addresses from the US Postal Service. SC DHHS will provide their beneficiary addresses to State IT, on a quarterly basis, which will match these addresses against the USPS database and return the file to SC DHHS. SC DHHS will update their database with the current addresses. The cost of a mailed letter that is discarded is over 40 cent per piece and more importantly the beneficiary does not receive the information from their health insurance program. The cost of the updated addresses is 30 cent per 1,000. So by preventing 1 returned letter out of every 1,000, the cost of the service is covered. Since several computer system updates are needed we will attempt an implementation by January 2010.

Finally the most comprehensive and complex change will be creating a consistent model for our eligibility offices. The problem of not being able to reach a caseworker

could be addressed by separating duties of eligibility workers so certain staff is dedicated to interact with the public while others are dedicated to processing cases. Also the concern of timeliness of cases being processed should be addressed by this change as well. Based on the complexity of this task we will use Charleston County as a pilot. Charleston has already implemented several changes to separate these functions.

Currently, there is an intake office in downtown Charleston that handles new applications only. Also, if clients need to bring in documentation they are allowed to do so as well. However this office as illustrated in Figure 13 shows that this office is setup in a hallway and is inadequate in serving the public. This property is managed by the Medical University of South Carolina (MUSC), thus SC DHHS does not govern the property. Local staff do not have private offices that will sit more than one person at a time; the four private offices on the left side of the hall are too small to close the door and thus computer screens are visible, a direct HIPAA violation. Also the reception area on the right side of the hall consists of eight windows that are supported by only two employees. The public perception is that the windows are not staffed properly. The receptionists also cannot see around the windows to determine if there are clients waiting and how many are waiting. A mirror has been requested but since MUSC handles these requests they have not been a priority. There is only one small visible sign to acknowledge where the Medicaid office is located and there is no visible designated area for parking. In Figure 14, you can see that beneficiaries are lined up on the wall on the right of the hall waiting on the receptionists at the windows on the right. You can also see the lady in the middle walking through the hall coming from the dental clinic at the end of the hall. The traffic is a major issue for both the dental clinic and Medicaid office. We

did find out that there is parking available however, the lot has three similar signs as displayed in Figure 15 at the entrance of the lot. Based on these signs the public would not realize this parking lot is available to them. It is my recommendation that we request MUSC to place a sign at the entrance to the parking lot that states that parking for SC DHHS clients is allowed and validated inside at the security desk. Parking for staff is off site and employees have to take a bus to the office. There is very limited space for any file cabinets, no space for break areas, and no meeting areas. These are just a handful of the issues that this local office is facing. I recommend that the local intake office for Charleston County be moved to a more conducive location that allows for public parking, allows the receptionists to manage the incoming traffic and allows the public a more comfortable environment.

Charleston County has a very nice complex for their processing and maintenance unit. This creates a definite inequality for the two different staffs that operate these two units. The processing and maintenance provides adequate parking, spacious offices and room for storing files. However there is no automated tool for sharing information between the two facilities. I recommend that scanning software and hardware be implemented at these locations. We will use Charleston as a pilot for this scanning project. Also, there is no consistent tracking system. The tracking documents are all manually handled documents. These are paper logs that are updated and stored in the intake facility and separate logs stored in the processing/maintenance area. These documents cannot be shared or accessed timely. Starting in March 2009, we will be developing a task force to review the current online tracking system used at the State Office central processing unit to determine what modifications need to be made to roll

out to the Charleston offices. By April 2009 we will implement the updated tracking system in Charleston for a three-month period. The goal is to use this time to adapt and modify the system to be as efficient and effective as possible. By having a central tracking system any worker should be able to provide updates to beneficiaries when phone calls come in. The next step will be to implement the updated system to all counties. We have solicited the USC GIS (geographical information system) division to assist us in our statewide rollout and to determine if our offices are located appropriately.

Evaluation Method:

At the end of 2009, we will review the MEDS reports to determine how many cases are now being closed for failure to return the review form for the same four month time period in 2009 compared to the same period in 2008. This should illustrate if the updated envelopes for our agency are having an impact on beneficiaries being able to identify the Healthy Connections logo and are opening and returning their Medicaid notifications. This measurement will be transparent to both the public and eligibility staff, so it should be an accurate representation of the cases being closed for failure to return the forms.

In at least 6 months after the implementation of the updated address file matching with State IT, we will review our new updated address statistics. This should also identify if our campaign to implement a new script for staff to use on all beneficiary calls to retrieve updated addresses has been successful. We will also survey our eligibility offices again to determine how many pieces of returned mail they are receiving.

It is our goal that the Charleston County pilot will be running by the end of 2009 with the eligibility office and processing unit both using the tracking and scanning

system. After a 3-6 month period we will survey the county staff to determine what value these changes have been made and how satisfied the staff is with the changes as well. The MEDS reports that display processing times will also be reviewed to determine if these changes have had a positive or negative impact on the processing time for the same time period for the last year. As stated in Process Improvement, "measurements must be used to measure and improve the process, not punish people"[3], therefore it is essential to make sure the measurement tools are accurate and effective for measuring these changes not for grading the staff at this time.

Conclusion:

The improvements outlined in this project hopefully will provide benefits to all parties in the Medicaid business in South Carolina. More importantly this project is focused on bridging the gap between State Office management and local eligibility staff. Hopefully with this project being focused on improving aspects of the day-to-day jobs for eligibility staff they will have buy-in to provide continuous feedback to management to assist in maintaining a continually improving eligibility process like our agency goals state. That component is essential in the success of creating a continually improving process. The feedback has to be provided and an avenue has to be there for it to be gathered and evaluation of that feedback has to be a priority for management of the eligibility area.

With over 500 employees involved in the eligibility process and with over 1,000,000 beneficiaries being served in a year there is a lot of room for issues and barriers to develop. It will take the entire agency to stay focused on our existing goals to

[3] Flanigan, Eileen M. and Scott, Jon. Process Improvement, p.32

truly maintain an accurate and efficient eligibility process. As Joiner stated in Fourth Generation Management, "everyone from the front lines to the executives understands and acts like they are all on the same team, working together to continually enhance customer satisfaction"[4]. This is the goal for SC DHHS and with the appropriate direction this goal is attainable sooner than later.

[4] Joiner, Brian L. Fourth Generation Management

Figure 1

Top complaints from beneficiaries concerning the Medicaid process

1. Policy	31%
2. Can't Reach Worker	19%
3. Notifications	11%
4. Timeliness	11%

Source: Survey 1, Question 2

Figure 2

What do you feel is the biggest barrier in the eligibility process?

1. Required Documentation	33%
2. Policy	25%
3. Other	17%
4. Beneficiary Interaction	14%
5. Supervisor/Mgmt.	11%

Source: Survey 2, Question 6

Figure 3

Percentage of time spent on each activity by workers

1. New app/Review Processing	27%
2. Other	17%
3. Phone with beneficiaries	17%
4. Documenting Work	16%
5. Face to face with beneficiaries	13%
6. Gathering reqd. documentation	7%

Source: Survey 2, Question 7

Figure 4

Do you or your office use a tracking system to track/log your work?

Yes	93.7%
No	6.3%

Source: Survey 2, Question 10

Figure 5

Please specify what you use to track/log your work.

1. Microsoft Excel	32%
2. Manual paper process	30%
3. MEDS Notes	21%
4. Microsoft Word	9%
5. Other	7%

Source: Survey 2, Question 11

Figure 6

How often do you get updated contact information from beneficiaries?

1. Time of new app/review	53%
2. When beneficiary informs me	27%
3. Every time I talk to beneficiary	14%
4. Other	6%

Source: Survey 2, Question 8

Figure 7

How many pieces of return mail do you receive a day?

1. 1 to 5 per day	46%
2. 5 to 10 per day	19%
3. 10 to 20 per day	13%
4. 0 per day	13%
5. More than 20 per day	8%

Source: Survey 2, Question 15

Figure 8

Closures for "Failure to Return Review Form"

June 2008	10,903
July 2008	9,675
Aug 2008	9,781
Sept 2008	10,756

Source: SC DHHS Decision Support System

Figure 9

Do you feel the eligibility process needs to be improved?

Yes	92%
No	8%

Source: Survey 2, Question 15

Figure 10

Which description best describes how you feel concerning your workload?

My caseload is large but manageable	46%
I can never get caught up	33%
My caseload is appropriate	13%

Source: Survey 2, Question 16

Figure 11: **Medicaid Review Envelopes (Top: Old Version, Bottom: New Version)**

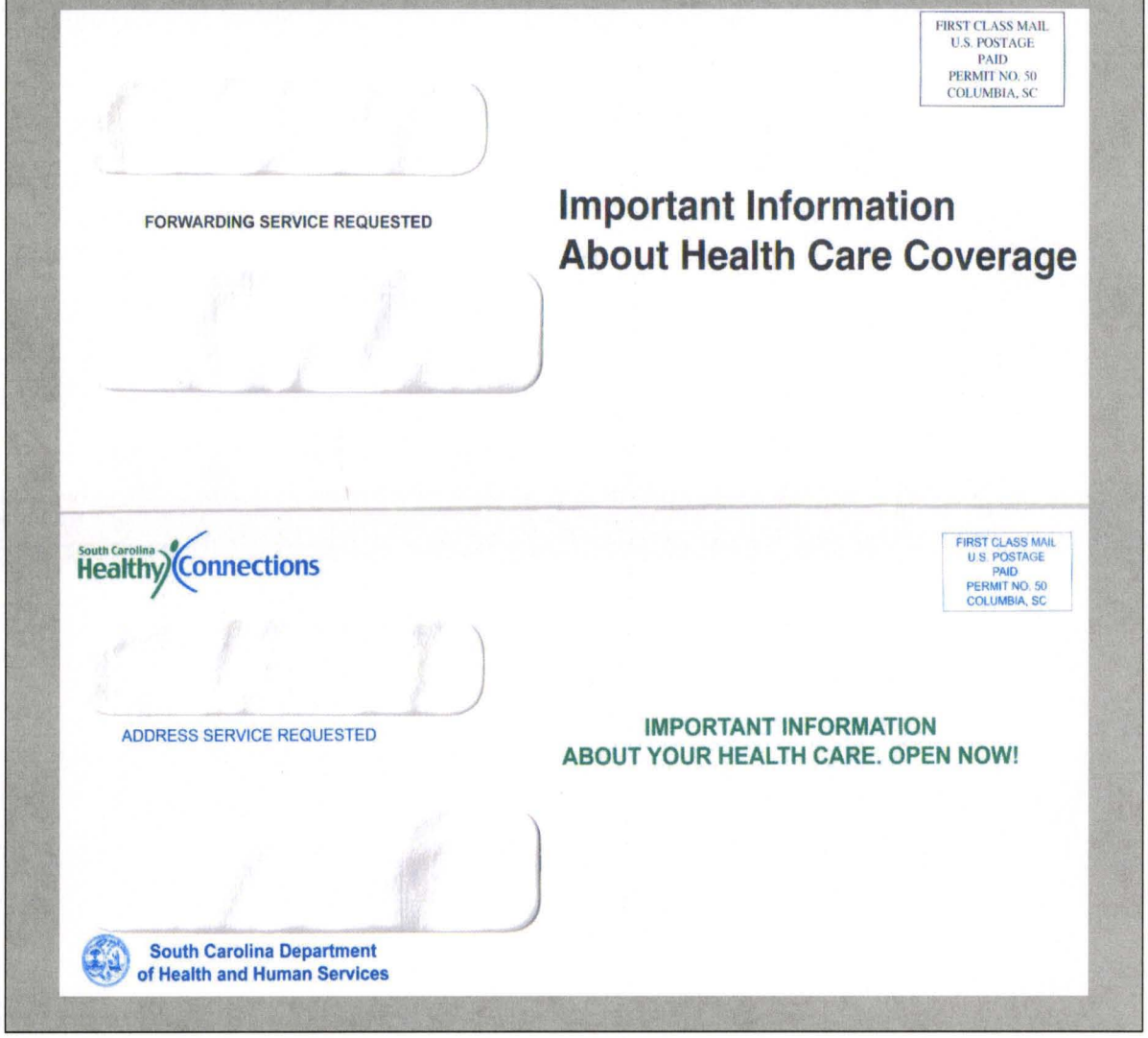

Figure 12: Regular Medicaid Envelopes (Top: Old Version, Bottom: New Version)

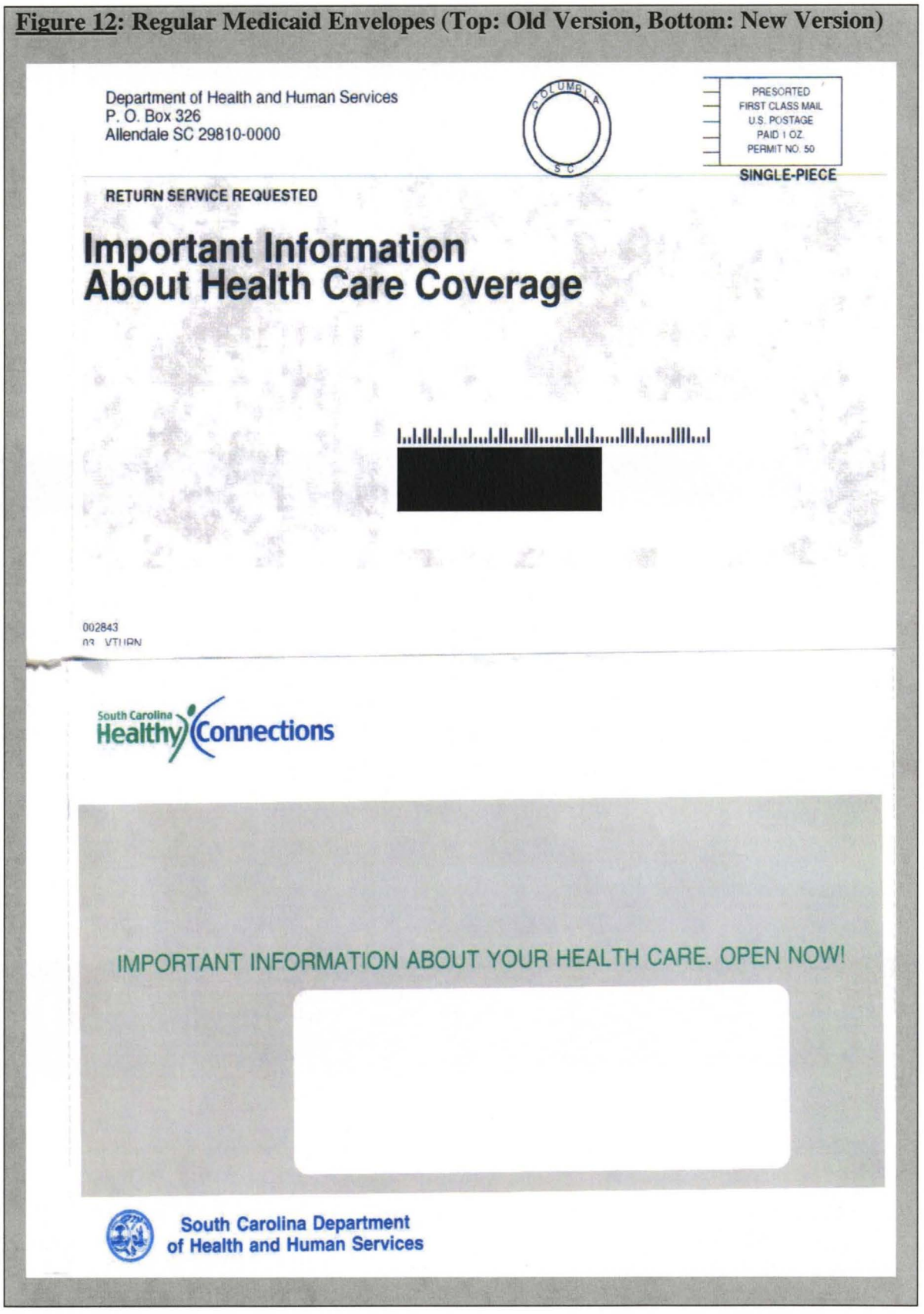

Figure 13: Charleston County Intake Office (Hall to Dental Clinic)

Figure 14: Charleston Intake Office with Beneficiaries and Dental Clinic traffic

Figure 15: One of three No Parking signs in front of parking lot for beneficiaries

Figure 16: SC DHHS Employee Survey #1 (Text only)

1. Please complete the following:
   First Name, Last Name, Today's Date, County/State Office, Office Location
2. Based on your interactions with beneficiaries, how would you rate the beneficiaries' satisfaction in the Medicaid Eligibility experience? (This is not an evaluation of you, but of the eligibility experience as a whole for a beneficiary based on your conversations with them.)
   1 = Very Poor, 2 = Poor, 3 = Neutral, 4 = Good, 5 = Very Good
3. What are the top five complaints you hear from beneficiaries concerning their Medicaid Eligibility experience?
4. What are the three things that beneficiaries' must do, that you think takes the most time?
5. What are the three things that you must do as an eligibility worker, that you think takes the most time?
6. What are some of the processes, procedures, paper work or any other part of the Medicaid Eligibility experience that you would change?

7. If you had one process, procedure or change you could put in place what would it be?

8. Do you feel that your office is set up properly to serve beneficiaries correctly?

Yes or No; If NO, what would you suggest?

9. If you have any other concerns or suggestions that are related to the overall Medicaid Eligibility experience please list them.

Figure 17: Eligibility Worker Survey #2 (Text only)

1. Please select the county and office type you are primarily stationed at.
2. Based on your interactions with beneficiaries, how would you rate the beneficiaries' satisfaction in the Medicaid Eligibility experience? (This is not an evaluation of you, but of the eligibility experience as a whole for a beneficiary based on your conversations with them.)

1 = Very Poor, 2 = Poor, 3= Neutral, 4= Good, 5 = Very Good

3. Please select which position best describes your primary role.

Admin/Clerical, Eligibility Input(only) Worker, Eligibility Review/Maintenance(only) Worker, Eligibility Worker (Input/Review/Maintenance), Eligibility Supervisor, Call Center, Other

4. Is your office set up into different units (such as: intake, processing and maintenance or fi cases vs. ssi cases)? If yes, please select which apply.

Yes or No

5. Please specify which apply to your office. Select as many as apply

Intake/Processing/Maintenance, FI Cases/SSI Cases, Other

6. What do you feel is the biggest barrier in the eligibility process? Rank 1 to 5, 1 as the biggest barrier and 5 as the least. (You can only use a ranking once for the entire question)

Policy (Rules/Procedures), Required Documentation, Supervisor/Management, Beneficiary Interactions (Face to Face/Phone), Other

7. Please provide the percentage of time you spend a day on each item (must add up to 100 percent).

Phone interaction with beneficiaries, Face to face interaction with beneficiaries, New application or review processing, Gathering required documentation, Documenting your work (tracking log), Other

8. How often do you get updated contact information from beneficiaries? (There is no wrong or right answer)

Time of New Application/Review, When beneficiary informs me (phone/face to face), Every time I communicate with beneficiary, Other

9. Do customers complain about the location of your office?

Yes or No

10. Do you or your office use a tracking system to track/log work?

Yes or No

11. Please specify what you use to track/log your work. Select as many as apply.
    Microsoft Excel spreadsheet, Microsoft Word document, Manual paper process, MEDS Notes, Other
12. How often do you participate in training on Eligibility (policy,procedures,MEDS,etc.)?
    Once a week, Once a month, Once every six months, Once every year, Usually over a year or more between classes, Do not attend formal training
13. Do you feel you are trained often enough to be successful?
    Yes or No
14. Do you feel the training you receive at HHS prepares you enough to be functional as a caseworker when you are back in the office?
    No, Somewhat, Yes, Not Applicable
15. How many pieces of return mail do you receive a day?
    1 to 5, 5 to 10, 10 to 20, More than 20, 0
16. Please select which description best describes how you feel concerning your workload.
    My caseload is appropriate, My caseload is large but manageable, I can never get caught up
17. Do you feel the eligibility process needs to be improved?
    Yes or No